Indiana State Department of Health

LTC Newsletter

LTC & ICF/MR HOMES

Volume 6, Issue 2 *Division of Long Term Care Publication* *September 2006*

IMMEDIATE JEOPARDY

Immediate jeopardy (IJ) occurs when noncompliance with a federal regulation has caused, or is likely to cause, serious injury, harm or death to a resident and immediate corrective action is, or was, needed to prevent serious harm from occurring.

An IJ must be removed within twenty-three (23) days from the date of exit conference or the facility will be terminated from Medicare and/or Medicaid Program(s). A civil money penalty will be imposed ranging from $3,050 to $10,000 for each day that IJ exists. State sanctions that can be imposed immediately include a ban on new admissions and the placement of a monitor at the facility's expense.

There has been a precipitous increase in the number of IJ over the last couple of years. So far this calendar year, the Division of Long Term Care has identified forty-five (45) situations of IJ in long term care and ICF-MR facilities, four (4) of which were not removed prior to survey exit. Below are examples of the situations being cited for IJ thus far this calendar year:

- The facility failed to ensure the supervision and safety of a resident when the resident exited the main building though an unlocked door into an unsupervised courtyard. The resident fell from a wheelchair during extremely hot weather conditions and remained there for a long length of time before being found.
- The facility's healthcare services neglected to implement written policy and procedures to prevent a resident from injury due to use of a restraint. The facility failed to administer medicine as ordered by a physician and to notify the physician of changes in the resident's condition.
- On two occasions the facility failed to prevent a resident who was an elopement risk from exiting a locked unit. The second time the resident fell down a stairwell and sustained a fracture.
- For a period of two weeks, the facility failed to provide necessary treatment to a resident who was admitted to the facility with an area of skin infection. As a result of the lack of treatment or preventive measures the area on the heel increased in size and became black in color.
- The facility neglected to implement written policy and procedures to protect residents from unprovoked attacks by a resident with a history of aggressive behaviors.
- The facility failed to repair a malfunctioning water heater which resulted in dishes and linens being washed at low temperatures for several days. This created a high potential for the spread of infection and illness.
- The facility failed to have a system in place to prevent a confused, aggressive and threatening resident from frightening and/or injuring himself and/or other residents.
- The facility failed to provide adequate supervision to cognitively impaired residents that smoked. Residents were not smoking in designed areas and continued to possess smoking materials after they were observed smoking independently in their rooms, bathrooms, or other inappropriate areas.

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Consultants Wanted

The Division of Long Term Care at the Indiana State Department of Health (ISDH), administrator of the Civil Money Penalty Fund Consultant Program, is seeking qualified individuals for inclusion in the program.

The program places consultants in participating long-term care facilities at no cost. The program is designed to assist facilities in achieving Medicare/ Medicaid compliance. Consultants, in conjunction with the facility staff, are responsible for developing a work plan to address facility specific issues and to provide professional consultation services to assist in implementation of the work plan. The Civil Money Penalty Fund pays the consulting fees.

The ISDH is currently seeking professionals in the following long-term care professional areas: Health Facility Administrators, Nurse Consultants, Registered Dieticians, Social Services, and Activities personnel. Qualified participants must attend a one-day mandatory training session and enter into a contract with the ISDH prior to placement in a participating facility.

Consultants may not be currently employed in their professional capacity by a long-term care facility. In addition, placement cannot be made within a facility in which the consultant has either been employed by or provided consultation to within the previous twenty-four (24) months.

To obtain an application packet, contact, Michael Dean, Program Director, Long Term Care at 317.233.7784 or by email to midean@isdh.IN.gov. The deadline for completed applications is December 31, 2006.

Long Term Care Provider Survey Questionnaire

Effective October 1, 2006 the Indiana State Department of Health's Division of Long Term Care will begin the distribution of the "Long Term Care Provider Survey Questionnaire" at the start of every Annual , Revisit, Complaint, and Life Safety Code Surveys. The questionnaire will give Providers the chance to evaluate the survey process. The purpose of the questionnaire is to improve the quality of the survey process through the responses to the questions contained in the survey. The information provided in the questionnaire will have no negative impact on the survey or subsequent survey activities in your facility. A copy of the "Long Term Care Provider Survey Questionnaire" can be found on page 8. Please contact Sue Hornstein, Director, Division of Long Term Care at 317-233-7289 if there are any questions about this process.

CNA Nurse Aide Registry Information Request

The Indiana State Department of Health (ISDH) requests that all incidents involving CNAs submitted to the ISDH include the CNA's Nurse Aide Registry number.

The ISDH requests CNA registry numbers to help distinguish between individuals with common names (e.g., Jane Smith), and to help protect individuals social security numbers from being unnecessarily revealed. Thank you for your cooperation.

Senate Enrolled Act Number 161

Pursuant to the 2006 Amendment to Indiana Code 16-29-3-1 (as directed in Senate Enrolled Act Number 161), the Indiana State Department of Health (ISDH) may not approve the certification of new or converted comprehensive beds for participation in a state reimbursement program, including Medicaid after July 1, 2006.

Section 2 (a) of the Amendment further defines "comprehensive care bed" as: licensed or is to be licensed under IC 16-28-2, functions as a bed licensed under IC 16-28-2; or subject to IC 16-28.

Section 2 (b) of the Amendment does not apply to a health facility licensed or to be licensed under Indiana Code 16-28 that is under development on June 30, 2006, to add, construct, or convert comprehensive care beds. In determining whether a health facility is under development on June 30, 2006, the ISDH shall consider whether:

- Architectural plans have been completed;
- Funding has been received;
- Zoning requirements have been met;
- Construction plans for the project have been approved by the Indiana State Department of Health's Division of Sanitary Engineering and the Division of Fire and Building Safety.

In addition any health facility attempting to gain Medicaid certification for newly constructed, added, or converted beds should contact the Office of Medicaid Policy and Planning at the Family and Social Services Administration (317-232-4650) before occupying those beds in order to ensure that a provider agreement will be issued.

A copy of Senate Enrolled Act Number 161 can be found on page 10 of this newsletter. For more information please contact the Program Director-Provider Services in the Division of Long Term Care at 317-233-7794.

New CMS Indiana Survey Team Leader

Joanna Pollock became the State Survey Team Leader for Indiana on August 7, 2006. Joanna is a registered dietitian. She was a state surveyor in Texas for 3 ½ years and has 2 years of CMS survey experience in the Dallas Regional Office. Joanna transferred to the Chicago Regional Office in March 2006 and has recently been working in the Michigan/ Ohio LTC branch.

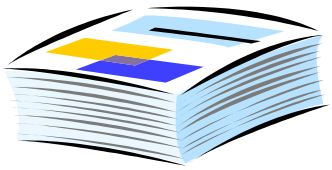
New Enforcement Staff

Miriam Buffington joined the staff of the Indiana State Department of Health's Division of Long Term Care replacing Stephen Upchurch as Enforcement Manager April 24, 2006. Miriam has worked in a variety of public and non-profit positions. Previously, she worked for the City of Indianapolis in the Office of Finance and Management. Prior to moving back to Indiana, Miriam worked for Memorial Medical Center in Springfield, Illinois and with the State of Illinois. She holds a Bachelor of Science degree from Indiana University's School of Public and Environmental Affairs in Bloomington, Indiana. Miriam is married with two children. She enjoys spending time with her family, gardening, reading, and hiking. Miriam may be reached at 317/233-7613 or by email at mbuffington@isdh.IN.gov.

Karina Gates became the Enforcement Coordinator for the Indiana State Department of Health's Division of Long Term Care on June 5, 2006, replacing Ryan Miller. Karina looks forward to this challenging new position and to serving the residents and families involved. Previously, Karina worked under Family and Social Services Administration for three years after graduating from Ball State University with a Bachelor's Degree in Health Science. Karina enjoys traveling, reading, shopping, and spending time with her family, especially her adorable four year old son, Izaak.

New ISDH Health Investigator

Linda Chase started her employment as a Health Investigator for the Indiana State Department of Health on July 17, 2006. Linda will be surveying unlicensed facilities and performing CNA investigations. Prior to working at the Indiana State Department of Health, Linda was an independent case manager serving clients on the Developmental Disability Medicaid Waivers. Her employment history also includes eight (8) years as a case manager with the Central Indiana Council on Aging working with elderly and disabled clients. Linda started her career as a Social Service Director in a local nursing home. She received her Bachelor's degree in Social Work in 1990 from the University of Illinois at Chicago. Linda is married with two children. She enjoys spending time with family and friends and reading. She is also involved with Greyhound Pets of American, an adoption organization for re-



Annual Reporting Requirement

The Indiana Administrative Code (410 IAC 16.2-3.1-13 (o)) requires that each nursing facility submit an annual statistical report to the Indiana State Department of Health. The Department has made some adjustments to the program this year. The form can now be downloaded from the ISDH web-site, filled out, saved, and then sent back to the ISDH via email. A hard copy of the form will also be distributed. An official memorandum, with the instructions and a hard copy of the form, will be distributed to all certified nursing facilities during the month of September in 2006 and then beginning in 2007 they will be distributed in early March. Each nursing facility is expected to submit the statistical report within sixty (60) days of its receipt. For more information please contact the Program Director-Provider Services in the Division of Long Term Care at 317-233-7794.

Hand Sanitizers

Antiseptic gels and foams have become a popular way to disinfect hands when soap and water are not available and can be effective in curbing the spread of infections. However, to be effective alcohol concentration should be between 60% and 95%. Studies have shown that gels with concentrations lower than 60% appear to spread the bacteria instead of killing them. Some sanitizers found on store shelves, as well as some recipes found on the internet contain significantly less alcohol.

Sanitizers do not work well for hands that are soiled with dirt, blood, feces or other body fluids and the use of soap and water is advised. To maximize the effectiveness of hand sanitizers vigorously rub all sides of your hands with enough gel or foam to get them wet and rub until dry. According to the Center for Disease Control and Prevention guidelines for healthcare workers if your hands are dry within 10-15 seconds then you haven't used enough.

Government Performance and Results Act Goals

The purpose the Government Performance and Results Act (GPRA) of 1993 is to improve the efficiency and effectiveness of Federal programs by establishing a system to set goals for program performance and to measure results. The Centers for Medicare and Medicaid Services (CMS) has determined that reducing pressure ulcers and restraints will be one of the primary GRPA goals for nursing facilities. The CMS Midwest Consortium issued a report entitled the "MWC Plan for Impacting GPRA Goals: Reducing Pressure Ulcers and Restraints" on May 1, 2006. The report presents a plan for state agencies to follow in an attempt to reduce pressure ulcers and restraints. It provides guidance in the following areas: CMS Central Office Initiatives, Regional Office Initiatives, State Agency Initiatives, State and Federal Surveyor Training, Reports and Data Analysis, the Survey Process, and Enforcement Related Actions. The contents of the report can be found on page 12 of this newsletter.

Governor Mitch Daniels' IN SHAPE INDIANA

Are you looking for a way to improve your health or the health of your family, staff, or patients? If so, you need to know about INShape Indiana and how to get involved.

INShape Indiana is Governor Mitch Daniels' statewide health initiative aimed at helping Hoosiers make healthy choices by linking them to valuable resources and offering a fun challenge to improve their health and well-being. INShape Indiana is not another program; it is an initiative to coordinate the many efforts taking place across the state to combat obesity and smoking.

The sad truth is that Indiana currently ranks 10th in obesity and 2nd in adult smoking. The poor health outcomes associated with obesity and smoking negatively impact the health of Hoosiers as well as the state's economy.

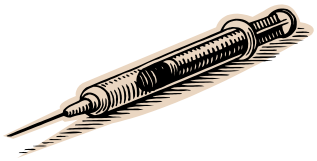
INShape Indiana promotes three simple health messages:

- Better nutrition
- Increased physical activity
- Stopping smoking

Log on to www.INShape.IN.gov to access the clearinghouse of information on programs, activities, and events from all over the state related to nutrition, physical activity, and tobacco cessation. You can also register to be an INShape Indiana participant and use the bi-weekly tracking mechanism to monitor your progress towards a healthier lifestyle. All participants have access to the incentives provided by the INShape Indiana partners. The website also offers the opportunity to celebrate individual and group success stories so be sure to tell us about your successes!

You will also want to check out the Health After 50 section of the INShape Indiana website. This section provides information on nutrition, physical activity, and wellness issues tailored to the needs of Hoosiers 50 years and older. This can be a great resource for Long Term Care facilities and the residents. Be sure to check future editions of this newsletter for specific tips on helping those over 50 to lead healthy, active lifestyles.

Pandemic Influenza



A flu pandemic occurs when a new influenza virus emerges for which people have little or no immunity and for which there is no vaccine. The disease spreads easily person-to-person, causes serious illness, and can sweep across the country and around the world in very short time. It is difficult to predict when the next influenza pandemic will occur or how severe it will be. Wherever and whenever a pandemic starts, everyone around the world is at risk.

The Indiana State Department of Health (ISDH) has developed a "Pandemic Influenza Plan" (http://www.in.gov/isdh/bioterrorism/PandemicFlu/pdfs/PandemicInfluenzaPlan.pdf). The Pandemic Influenza Plan attempts to establish strategies and policies in the event that a flu pandemic occurs in the State of Indiana. Health care providers should familiarize themselves with this plan.

The United States Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) have also developed a checklist to help long-term care and other residential facilities assess and improve their preparedness for responding to pandemic influenza. A copy of the "HHS Long-Term Care and Other Residential Facilities Pandemic Influenza Planning Checklist" can be found on 15 of this newsletter. Other information concerning Pandemic Influenza can be found at http://www.pandemicflu.gov/.

ICF-MR Information Reconsideration Meetings

Recently there has been some confusion regarding the purpose and intent of Informal Reconsideration Meetings in the ICF-MR survey and certification program. The purpose of this article is to clarify the expectations of Informal Reconsideration Meetings.

When a termination or cancellation date is set based upon survey findings, a facility is notified in writing of this date by the Enforcement department of ISDH's Division of Long-Term Care. In the letter the facility is advised of its right to request an Informal Reconsideration.

In advance of the meeting the facility should be collecting evidence demonstrating it has brought the deficient practices back into compliance. Once a facility requests a meeting and the meeting date is set, the facility may forward copies of this collected evidence to the appropriate ICF-MR surveyor supervisor who will review the evidence in advance of the meeting. During the meeting the facility will be given a chance to explain the evidence and add any additional information. The focus for the facility is demonstrating to ISDH the facility, at the time of the Informal Reconsideration, is once again in compliance with all the Conditions of Participation and related standards of the ICF-MR program, and particularly with those deficient practices cited on the most recent survey.

Once the facility has proven to ISDH the facility has offered sufficient evidence to warrant an additional on-site survey, the Enforcement Department will authorize the ICF-MR surveyor supervisor to schedule a survey, which will be unannounced and will occur between the conclusion of the Informal Reconsideration meeting and the certification cancellation or termination date. Even though this survey is focused to determine compliance with previously cited deficiencies, if a facility is found to be non-compliant with Conditions of Participation or any related standards the facility's Medicaid certification will stop on the previously determined date of cancellation or termination. If the survey finds that all previously cited deficiencies have been brought back into compliance, and no new deficiencies were cited during the focused survey, the termination/ cancellation dates will be rescinded by ISDH and the certification continues for the facility.

If you have any questions regarding the Informal Reconsideration meeting process, feel free to contact the Miriam Buffington; Enforcement Manager for ISDH's Division of Long-Term Care. She can be reached at 317-233-7613 or e-mail mbuffington@isdh.in.gov.

National Provider Identifier: Get It. Share It. Use It.

As the industry transitions to NPI compliance, remember that there is no charge to get an NPI. Providers can apply online for their NPI, free of charge, by visiting https://nppes.cms.hhs.gov or by calling 1-800-465-3203 to request a paper application. The CMS NPI page, located at www.cms.hhs.gov/NationalProvIdentStand/ , is the only source for official and authoritative education on the NPI initiative; all products located on this site are free of charge.

CMS continues to urge providers to include legacy identifiers on their NPI applications, not only for Medicare but for all payers. If reporting a Medicaid number, include the associated State name. If providers have already applied for their NPI, CMS asks them to go back into the NPPES and update their information with their legacy identifiers. This information is critical for payers in the development of crosswalks to aid in the transition to the NPI.

REMINDER: The National Plan and Provider Enumeration System (NPPES) will be down for scheduled maintenance on August 2nd and 3rd , and will return to operation on August 4th after 8:00 a.m., Eastern Time.

Getting an NPI is free - not having one can be costly. More information on NPI can be found on page 12 of this newsletter.

Indiana State Department of Health

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Indiana State Department Of Health
Division of Long Term Care

TELEPHONE GUIDE

Arranged alphabetically by subject

All are Area Code 317

SUBJECT	CONTACT PERSON	EXTENSION
Administrator/DON, Facility Name/Address Changes	Seth Brooke	233-7794
Bed Change Requests (Changing/Adding Licensed Bed/Classifications)	Seth Brooke	233-7794
CNA Registry	Automated	233-7612
CNA Investigations	Zetra Allen	233-7772
CNA/QMA Training	Nancy Adams	233-7480
Director, Division of Long Term Care	Suzanne Hornstein	233-7289
Enforcement & Remedies	Miriam Buffington	233-7613
Facility Data Inquiries	Sarah Roe	233-7904
FAX, Administration		233-7322
Incidents/Unusual Occurrences	Fax Voicemail Other	233-7494 233-5359 233-7442
Informal Dispute Resolution	Susie Scott	233-7651
License/Ownership Verification Information	Seth Brooke	233-7794
License Renewal	Seth Brooke	233-7794
Licensed Facility Files (Review/Copies)	Darlene Jones	233-7351
Licensure & Certification Applications/Procedures (for New Facilities and Changes of Ownership)	Seth Brooke	233-7794
Life Safety Code	Rick Powers	233-7471
MDS/RAI Clinical Help Desk	Gina Berkshire	233-4719
MDS Technical Help Desk	Technical Help Desk Staff	233-7206
Monitor Program	Debbie Beers	233-7067
Plans of Correction (POC), POC Extensions & Addenda	Area Supervisors	See Below
Plans & Specifications Approval (New Construction & Remodeling)	Dennis Ehlers	233-7588
Reporting	Seth Brooke	233-7541
Rules & Regulations Questions	Debbie Beers	233-7067
Survey Manager	Kim Rhoades	233-7497
Transfer/Discharge of Residents	Seth Brooke	233-7479
Unlicensed Homes/Facilities	Linda Chase	233-7095
Waivers (Rule/Room Size Variance/ Nursing Services Variance)	Seth Brooke	233-7794
Web Site Information	Sarah Roe	233-7904

AREA SUPERVISORS

Area 1	Judi Navarro	233-7617
Area 2	Brenda Meredith	233-7321
Area 3	Brenda Buroker	233-7080
Area 4	Zetra Allen	233-7772
Area 5	Karen Powers	233-7753
Area 6	Pat Nicolaou	233-7441
Life Safety Code	Rick Powers	233-7471
ICF/MR North	Chris Greeney	233-7894
ICF/MR South	Steve Corya	233-7561

Updated 08/2006

Web Sites of Note

Indiana State Department of Health Web Page
http://www.in.gov/isdh/

Health Care Regulatory Services Commission Web Page
http://www.in.gov/isdh/regsvcs/

Certified Nurse Aide Registry
http://www.in.gov/isdh/regsvcs/acc/cerhha/

Consumer Guide to Nursing Homes
http://www.in.gov/isdh/regsvcs/ltc/profile/index.htm

CNAs with Verified Findings
http://www.in.gov/isdh/regsvcs/ltc/cnafind/index.htm

Centers for Medicaid and Medicare Services (CMS)
http://www.cms.hhs.gov/

How to read a survey
http://www.in.gov/isdh/regsvcs/ltc/readsurvey/index.htm

ICF/MR Facility Directory
http://www.in.gov/isdh/regsvcs/ltc/icfmrdir/index.htm

Laws, Rules, and Regulations
http://www.in.gov/isdh/regsvcs/ltc/lawrules/index/htm

Long Term Care Facilities Director
http://www.in.gov/isdh/regsvcs/ltc/directory/

LTC Newsletters
http://www.in.gov/isdh/regsvcs/acc/newsletter/index.htm

MDS Bulletins
http://www.in.gov/isdh/regsvcs/acc/oasis/

Non-Cert. Comp. Care Facility Dir.
http://www.in.gov/isdh/regsvcs/ltc/nccdir/index.htm

Nurse Aide Training Guide
http://www.in.gov/isdh/regsvcs/ltc/naguide/index.htm

Nurse Aide Training Sites
http://www.in.gov/isdh/regsvcs/ltc/natdir/index.htm

Nursing Home Compare (CMS)
http://www.medicare.gov/nhcompare/home.asp

Questions About Healthcare
http:// www.in.gov/isdh/regsvcs/ltc/questions/index.htm

Report Cards
http://www.in.gov/isdh/regsvcs/ltc/repcard/index.htm

Residential Care Facilities Directory
http://www.in.gov/isdh/regsvcs/ltc/resdir/index.htm

Retail Food Establishment Sanitation
http://www.in.gov/isdh/regsvcs/foodprot/retail.htm

State Operations Manual
http://www.cms.hhs.gov/manuals/IOM/list.asp

TB Skin Testing Course
http://www.in.gov/isdh/programs/tb/tb_train.htm

Access Indiana
http://www.in.gov/

Indiana Secretary of State
http://www.in.gov/sos/

State Forms Online PDF Catalog
http://www.state.in.us/icpr/webfile/formsdiv/index.html

AdminaStar Federal
http://www.adminastar.com

Family and Social Services Administration- Aging:
http://www.in.gov/fssa/elderly/

Family and Social Services Administration- Healthcare
http://www.in.gov/fssa/programs/healthcare/

Indiana Medicaid
http://www.indianamedicaid.com/ihcp/index.asp

US Government Printing Office
http://www.gpo.gov/

Indiana State Police
http://www.in.gov/isp/

MDS Web Site
http://www.cms.hhs.gov/MinimumDataSets20/

Reporting a Complaint
http://www.in.gov/isdh/regsvcs/ltc/complaints/index.htm

LONG TERM CARE
PROVIDER SURVEY QUESTIONNAIRE

The Indiana State Department of Health, Long Term Care Division (LTC) recently performed a survey in your facility. Please evaluate the LTC survey performance by taking a few minutes to complete and return this questionnaire.

Your completion and return of this questionnaire will help the Long Term Care Division continue to improve the survey process, and thereby to serve you and others more effectively.

The purpose of this questionnaire is to improve the quality of the survey process through your responses to the questions contained herein. The information in this questionnaire will have no negative impact on the survey or subsequent survey activities in your facility.

Thank You,

Sue Hornstein, Director
Long Term Care Division

PLEASE RETURN THIS FORM TO: SUE HORNSTEIN, DIRECTOR OF LONG TERM CARE IN THE PROVIDED ENVELOPE WITHIN 2 DAYS OF SURVEY EXIT

Using the scale below, please check the number that applies.
5: Strongly Agree **4:** Agree **3:** Neutral **2:** Disagree **1:** Strongly Disagree **NA:** Not Applicable

QUESTION:	**5**	**4**	**3**	**2**	**1**	**NA**	**COMMENT:**
1. Survey process was clearly explained.							
2. Surveyor conducted the survey in such a manner to minimize disruption of the facility's routine.							
3. Client/patient/resident reaction to the survey was positive.							
4. Communication with surveyor(s) was on-going during survey.							
5. Provider/facility had opportunity to discuss daily survey concerns with the surveyor(s).							
6. Received knowledgeable response from surveyor(s) if provider/facility requested clarification during survey process.							

Using the scale below, please check the number that applies.
5: Strongly Agree **4:** Agree **3:** Neutral **2:** Disagree **1:** Strongly Disagree **NA:** Not Applicable

QUESTION:	**5**	**4**	**3**	**2**	**1**	**NA**	**COMMENT:**
7. The survey was conducted in a professional and courteous manner – surveyor(s) interacted with staff in a respectful manner.							
8. Surveyor(s) interacted respectfully with facility residents.							
9. Surveyor(s) maintained confidentiality and privacy during conversations and survey observations.							
10. Adequate information was provided during the exit conference to allow facility staff to understand any areas of non-compliance.							

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2005 Regular Session of the General Assembly.

SENATE ENROLLED ACT No. 161

AN ACT to amend the Indiana Code concerning health.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 16-29-3-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2006]: Sec. 1. ~~Notwithstanding IC 16-29-1,~~ A hospital licensed under IC 16-21-2 may convert:

(1) ~~beginning January 1, 1986,~~ not more than thirty (30) acute care beds to skilled care comprehensive long term care beds; and

(2) ~~beginning June 1, 1989,~~ not more than an additional twenty (20) acute care beds to either intermediate care comprehensive long term care beds or skilled care comprehensive long term care beds;

that are to be certified for participation in a state or federal reimbursement program, including ~~programs~~ **a program** under Title XVIII ~~or Title XIX~~ of the Social Security Act (42 U.S.C. 1395 et seq.) or ~~42 U.S.C. 1396 et seq.);~~ **the state Medicaid program,** if those beds will function essentially as beds licensed under IC 16-28.

SECTION 2. [EFFECTIVE JULY 1, 2006] **(a) As used in this SECTION, "comprehensive care bed" means a bed that:**

(1) is licensed or is to be licensed under IC 16-28-2;

(2) functions as a bed licensed under IC 16-28-2; or

(3) is subject to IC 16-28.

The term does not include a comprehensive care bed that will be used solely to provide specialized services and that is subject to IC 16-29.

(b) This SECTION does not apply to the following:

(1) A hospital licensed under IC 16-21-2 that in accordance with IC 16-29-3-1, as amended by this act, converts not more than:

(A) thirty (30) acute care beds to skilled care comprehensive long term care beds; and

(B) an additional twenty (20) acute care beds to either intermediate care comprehensive long term care beds or skilled care comprehensive long term care beds;

that are to be certified for participation in a state or federal reimbursement program, including a program under Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or the state Medicaid program, if those beds will function essentially as beds licensed under IC 16-28.

(2) A health facility licensed or to be licensed under IC 16-28 that is under development on June 30, 2006, to add, construct, or convert comprehensive care beds. In determining whether a health facility is under development on June 30, 2006, the state department shall consider:

(A) whether:

(i) architectural plans have been completed;

(ii) funding has been received;

(iii) zoning requirements have been met; and

(iv) construction plans for the project have been approved by the state department and the division of fire and building safety; and

(B) any other evidence that the state department determines is an indication that the health facility is under development.

(c) Comprehensive care beds may not be added or constructed in Indiana.

(d) Residential beds licensed under IC 16-28-2 and unlicensed beds may not be converted to comprehensive care beds.

(e) The Indiana health facilities council may not recommend and the state department of health may not approve the certification of new or converted comprehensive care beds for participation in a state reimbursement program, including the state Medicaid program.

(f) This SECTION expires June 30, 2007.

MWC Plan for Impacting GPRA Goals: Reducing Pressure Ulcers and Restraints May 1, 2006

Central Office Initiatives

- Investigate with the Survey and Certification Group in CMSO and OCSQ the feasibility of:
  - A notice to problematic facilities via their "QIES to Success Homepage."
  - Appointing a national lead on the GPRA Goals
  - Ensuring that there is current guidance available to providers via a satellite broadcast on the subjects. Ensure that the existing broadcast on pressure ulcers is extended for viewing for an additional year.
  - Devote two SNF Open Door Calls to the subject. Jan 18
  - A library of references will be developed to give to providers. This could include texts, links to websites, QIO addresses, Internet Streaming links to CMS Satellite broadcasts, etc.
  - Data will be provided by CMSO on a quarterly basis, as the MDS data is refreshed, so that we can track progress.

RO/SA Initiatives

- Involve State Survey Agencies in our approach to the problem for early buy-in.
- Coordinate our work with the Division of Quality Improvement in the Kansas City Regional Office and with the QIOs.
- Involve the State LTC Ombudsman in the plan. Discuss with them at the regular RO-Ombudsman calls.
- Request States that have had early successes in either goal (such as Wisconsin in restraint reduction) provide us with the techniques they used. .
- Investigate the feasibility of a State mailing to the facilities with the poorest performance (e.g., highest incidence and most deficiencies) putting them on notice.
- Assign a GPRA lead at each State and Regional Office to participate in the MWC GPRA Task Force. Provide updates at each SA/RO Conference Call and meeting
- Share this plan with the LTC Industry in each State.

Training

- Ensure that every State and Federal surveyor is properly trained in Restraints and Pressure ulcers…regulations and best practices. Include the importance of assessments and the relationship of falls to restraints.
- Facilitate the opportunity for training of providers on reduction of Pressure Ulcers and Restraints in each State, working through the QIO, the SA, the

nursing home associations, previous CMS Satellite broadcasts, and/or the Medical Directors Association.

Reports and Data Analysis

- OSCAR data will be used to develop a list of every nursing home that reflects the number and percent of residents in each home in restraints and with pressure ulcers, as well as identifying the frequency with which the facilities have been cited deficient at F221 and F314. (User defined reports that identify the frequency of restraints and pressure ulcers are already in use in Illinois and Indiana by the State Leaders.) Of course, the incidence data (whose source is from the facility reported CMS-672) must be tempered prior to the survey by the MDS based, and more current, QI/QM reports.
- These reports will be developed for each MWC State and used by all federal surveyors in selecting facilities for FOSS/Comparative surveys. A facility with a high rate of restraint/pressure ulcers will always be selected over other facilities for FOSS and Comparative surveys.
- The reports will also be used by State survey teams in advance of all standard surveys and any complaint survey in which the complaint is related to the subjects.
- The reports will also be used by State and RO certification and enforcement staff for consideration in issuing enforcement actions. For example, enforcement staff should consider whether different or additional remedies would be appropriate for a facility that has a history of deficiencies at either tag, and that has a high incidence of residents with restraints and pressure ulcers

Survey Process

- State and Federal surveyors will investigate when there is evidence that residents were admitted with pressure ulcers from specific hospitals. If trends are indicated, the identity of those hospitals will be reported to the Regional Office for consideration in reporting to the JCAHO/AOA, or for a substantial allegation survey.
- On all standard surveys, Federal and State surveyors will review the QI/QM Reports and the completed CMS-672 with the facility representative to ensure that restraints and pressure ulcers have been reported (on both the MDS and the CMS-672) accurately.
- On FOSS's, Federal surveyors will pay strict attention to how well the State Agency surveyors evaluate the nursing home's performance as it relates to restraints and pressure ulcers. When these two matters are identified as a concern, this will always be recorded in Measures 1, 2, 3, and 6 of the FOSS report.

Enforcement Related Actions

- The RO's and the States will consider the immediate imposition of appropriate remedies against such a facility without an opportunity to correct, should deficiencies in restraints and pressure ulcers surface on surveys.
- While the provision of in-service training is usually part of any facility's plan of correction, the remedy of Directed In-service Training should seriously be considered (either alone or with additional remedies) under those circumstances. That is because the remedy would be carried out by experts from outside the facility system, and subject to State approval.
- Enforcement notices to non-compliant facilities would include a reference to the GPRA goals, and would include a specific recommendation for the facility to contact the QIO for assistance, to notify their Medical Director, and include a reference to CMS' website for further clinical guidance. Canned language would be prepared that would be easy to incorporate into the letters. An alternative approach would be to include this as an enclosure with State and Federal notices.

LONG-TERM CARE AND OTHER RESIDENTIAL FACILITIES PANDEMIC INFLUENZA PLANNING CHECKLIST

Planning for pandemic influenza is critical for ensuring a sustainable healthcare response. The Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) have developed this checklist to help long-term care and other residential facilities assess and improve their preparedness for responding to pandemic influenza. Based on differences among facilities (e.g., patient/resident characteristics, facility size, scope of services, hospital affiliation), each facility will need to adapt this checklist to meet its unique needs and circumstances. This checklist should be used as one tool in developing a comprehensive pandemic influenza plan. Additional information can be found at www.pandemicflu.gov. Information from state, regional, and local health departments, emergency management agencies/authorities, and trade organizations should be incorporated into the facility's pandemic influenza plan. Comprehensive pandemic influenza planning can also help facilities plan for other emergency situations.

This checklist identifies key areas for pandemic influenza planning. Long-term care and other residential facilities can use this tool to self-assess the strengths and weaknesses of current planning efforts. Links to websites with helpful information are provided throughout this document. However, it will be necessary to actively obtain information from state and local resources to ensure that the facility's plan complements other community and regional planning efforts.

1. Structure for planning and decision making.

Completed	In Progress	Not Started	
☐	☐	☐	**Pandemic influenza has been incorporated into emergency management planning and exercises for the facility.**
☐	☐	☐	**A multidisciplinary planning committee or team[1] has been created to specifically address pandemic influenza preparedness planning.**
			(List committee's or team's name.) _____
☐	☐	☐	**A person has been assigned responsibility for coordinating preparedness planning, hereafter referred to as the pandemic influenza response coordinator. (Insert name, title and contact information.)** _____
			_____
☐	☐	☐	**Members of the planning committee include (as applicable to each setting) the following: (Develop a list of committee members with the name, title, and contact information for each personnel category checked below and attach to this checklist.)**

- ☐ Facility administration
- ☐ Medical director
- ☐ Nursing administration
- ☐ Infection control
- ☐ Occupational health
- ☐ Staff training and orientation
- ☐ Engineering/maintenance services
- ☐ Environmental (housekeeping) services
- ☐ Dietary (food) services
- ☐ Pharmacy services
- ☐ Occupational/rehabilitation/physical therapy services
- ☐ Transportation services
- ☐ Purchasing agent
- ☐ Facility staff representative
- ☐ Other member(s) as appropriate (e.g., clergy, community representatives, department heads, resident and family representatives, risk managers, quality improvement, direct care staff, collective bargaining agreement union representatives)

1. An existing emergency or disaster preparedness team may be assigned this responsibility.

1. Structure for planning and decision making *(continued).*

Completed	In Progress	Not Started	
☐	☐	☐	Local and state health departments and provider/trade association points of contact have been identified for information on pandemic influenza planning resources. (Insert name, title and contact information for each.) Local health department contact: _____ State health department contact: _____ State long-term care professional/trade association: _____ _____
☐	☐	☐	Local, regional, or state emergency preparedness groups, including bioterrorism/communicable disease coordinators points of contact have been identified. (Insert name, title and contact information for each.) City: _____ County: _____ Other regional: _____
☐	☐	☐	Area hospitals points of contact have been identified in the event that facility residents require hospitalization or facility beds are needed for hospital patients being discharged in order to free up needed hospital beds. (Attach a list with the name, title, and contact information for each hospital.)
☐	☐	☐	The pandemic influenza response coordinator has contacted local or regional pandemic influenza planning groups to obtain information on coordinating the facility's plan with other influenza plans.

2. Development of a written pandemic influenza plan.

Completed	In Progress	Not Started	
☐	☐	☐	Copies have been obtained of relevant sections of the HHS Pandemic Influenza Plan (available at www.hhs.gov/pandemicflu/plan/) and available state, regional, or local plans are reviewed for incorporation into the facility's plan.
☐	☐	☐	The facility plan includes the elements listed in #3 below.
☐	☐	☐	The plan identifies the person(s) authorized to implement the plan and the organizational structure that will be used.

3. Elements of an influenza pandemic plan.

Completed	In Progress	Not Started	
☐	☐	☐	**A plan is in place for surveillance and detection of the presence of pandemic influenza in residents and staff.** ☐ A person has been assigned responsibility for monitoring public health advisories (federal and state), and updating the pandemic response coordinator and members of the pandemic influenza planning committee when pandemic influenza has been reported in the United States and is nearing the geographic area. For more information, see www.cdc.gov/flu/weekly/fluactivity.htm. (Insert name, title and contact information of person responsible.) _____ _____ ☐ A written protocol has been developed for weekly or daily monitoring of seasonal influenza-like illness in residents and staff. For more information, see www.cdc.gov/flu/professionals/diagnosis/. (Having a system for tracking illness trends during seasonal influenza will ensure that the facility can detect stressors that may affect operating capacity, including staffing and supply needs, during a pandemic.) ☐ A protocol has been developed for the evaluation and diagnosis of residents and/or staff with symptoms of pandemic influenza. ☐ Assessment for seasonal influenza is included in the evaluation of incoming residents. There is an admission policy or protocol to determine the appropriate placement and isolation of patients with an influenza-like illness. (The process used during periods of seasonal influenza can be applied during pandemic influenza.)

3. Elements of an influenza pandemic plan *(continued)*.

Completed	In Progress	Not Started	
			❑ A system is in place to monitor for, and internally review transmission of, influenza among patients and staff in the facility. Information from this monitoring system is used to implement prevention interventions (e.g., isolation, cohorting). (This system will be necessary for assessing pandemic influenza transmission.)
❑	❑	❑	**A facility communication plan has been developed.** **For more information, see www.hhs.gov/pandemicflu/plan/sup10.htm.**
			❑ Key public health points of contact during an influenza pandemic influenza have been identified. (Insert name, title and contact information for each.)
			❑ Local health department contact: _____
			❑ State health department contact: _____
			❑ A person has been assigned responsibility for communications with public health authorities during a pandemic. (Insert name, title and contact information.) _____
			_____
			❑ A person has been assigned responsibility for communications with staff, residents, and their families regarding the status and impact of pandemic influenza in the facility. (Having one voice that speaks for the facility during a pandemic will help ensure the delivery of timely and accurate information.)
			❑ Contact information for family members or guardians of facility residents is up-to-date.
			❑ Communication plans include how signs, phone trees, and other methods of communication will be used to inform staff, family members, visitors, and other persons coming into the facility (e.g., sales and delivery people) about the status of pandemic influenza in the facility.
			❑ A list has been created of other healthcare entities and their points of contact (e.g., other long-term care and residential facilities, local hospitals' emergency medical services, relevant community organizations [including those involved with disaster preparedness]) with whom it will be necessary to maintain communication during a pandemic. (Insert location of contact list and attach a copy to the pandemic plan.)
			_____
			❑ A facility representative(s) has been involved in the discussion of local plans for inter-facility communication during a pandemic.
❑	❑	❑	**A plan is in place to provide education and training to ensure that all personnel, residents, and family members of residents understand the implications of, and basic prevention and control measures for, pandemic influenza.**
			❑ A person has been designated with responsibility for coordinating education and training on pandemic influenza (e.g., identifies and facilitates access to available programs, maintains a record of personnel attendance). (Insert name, title, and contact information.) _____
			_____
			❑ Current and potential opportunities for long-distance (e.g., web-based) and local (e.g., health department or hospital-sponsored) programs have been identified. See www.cdc.gov/flu/professionals/training/.
			❑ Language and reading-level appropriate materials have been identified to supplement and support education and training programs (e.g., available through state and federal public health agencies such as www.cdc.gov/flu/groups.htm and through professional organizations), and a plan is in place for obtaining these materials.
			❑ Education and training includes information on infection control measures to prevent the spread of pandemic influenza.
			❑ The facility has a plan for expediting the credentialing and training of non-facility staff brought in from other locations to provide patient care when the facility reaches a staffing crisis.
			❑ Informational materials (e.g., brochures, posters) on pandemic influenza and relevant policies (e.g., suspension of visitation, where to obtain facility or family member information) have been developed or identified for residents and their families. These materials are language and reading-level appropriate, and a plan is in place to disseminate these materials in advance of the actual pandemic. For more information, see www.cdc.gov/flu/professionals/infectioncontrol/index.htm and www.cdc.gov/flu/groups.htm.

3. Elements of an influenza pandemic plan *(continued)*.

Completed	In Progress	Not Started	
❑	❑	❑	**An infection control plan is in place for managing residents and visitors with pandemic influenza that includes the following: (For information on infection control recommendations for pandemic influenza, see www.hhs.gov/pandemicflu/plan/sup4.html.)**
❑	❑	❑	An infection control policy that requires direct care staff to use Standard (www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html) and Droplet Precautions (i.e., mask for close contact) (www.cdc.gov/ncidod/dhqp/gl_isolation_droplet.html) with symptomatic residents.
❑	❑	❑	A plan for implementing Respiratory Hygiene/Cough Etiquette throughout the facility. (See www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm.)
❑	❑	❑	A plan for cohorting symptomatic residents or groups using one or more of the following strategies:[2] 1) confining symptomatic residents and their exposed roommates to their room, 2) placing symptomatic residents together in one area of the facility, or 3) closing units where symptomatic and asymptomatic residents reside (i.e., restricting all residents to an affected unit, regardless of symptoms). The plan includes a stipulation that, where possible, staff who are assigned to work on affected units will not work on other units.
❑	❑	❑	Criteria and protocols for closing units or the entire facility to new admissions when pandemic influenza is in the facility have been developed.
❑	❑	❑	Criteria and protocols for enforcing visitor limitations have been developed.
❑	❑	❑	**An occupational health plan for addressing staff absences and other related occupational issues has been developed that includes the following:**
❑	❑	❑	❑ A liberal/non-punitive sick leave policy that addresses the needs of symptomatic personnel and facility staffing needs. The policy considers: - The handling of personnel who develop symptoms while at work. - When personnel may return to work after having pandemic influenza. - When personnel who are symptomatic, but well enough to work, will be permitted to continue working. - Personnel who need to care for family members who become ill.
			❑ A plan to educate staff to self-assess and report symptoms of pandemic influenza before reporting for duty.
			❑ A list of mental health and faith-based resources that will be available to provide counseling to personnel during a pandemic.
			❑ A system to monitor influenza vaccination of personnel.
			❑ A plan for managing personnel who are at increased risk for influenza complications (e.g., pregnant women, immunocompromised workers) by placing them on administrative leave or altering their work location.
❑	❑	❑	**A vaccine and antiviral use plan has been developed.**
			❑ CDC and state health department websites have been identified for obtaining the most current recommendations and guidance for the use, availability, access, and distribution of vaccines and antiviral medications during a pandemic. For more information, see www.hhs.gov/pandemicflu/plan/sup6.html and www.hhs.gov/pandemicflu/plan/sup7.html.
			❑ HHS guidance has been used to estimate the number of personnel and residents who would be targeted as first and second priority for receipt of pandemic influenza vaccine or antiviral prophylaxis. For more information, see www.hhs.gov/pandemicflu/plan/sup6.html and www.hhs.gov/pandemicflu/plan/sup7.html.
			❑ A plan is in place for expediting delivery of influenza vaccine or antiviral prophylaxis to residents and staff as recommended by the state health department.

2. CDC guidance on preventing and controlling influenza transmission in long-term care facilities will be a useful resource during pandemic influenza. (See www.cdc.gov/flu/professionals/infectioncontrol/longtermcare.htm.)

3. Elements of an influenza pandemic plan *(continued).*

Completed	In Progress	Not Started	
❑	❑	❑	**Issues related to surge capacity during a pandemic have been addressed.**
			❑ A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations.
			❑ A person has been assigned responsibility for conducting a daily assessment of staffing status and needs during an influenza pandemic. (Insert name, title and contact information.)
			_____
			❑ Legal counsel and state health department contacts have been consulted to determine the applicability of declaring a facility "staffing crisis" and appropriate emergency staffing alternatives, consistent with state law.
			❑ The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis.
			❑ Estimates have been made of the quantities of essential materials and equipment (e.g., masks, gloves, hand hygiene products, intravenous pumps) that would be needed during a six-week pandemic.
			❑ A plan has been developed to address likely supply shortages, including strategies for using normal and alternative channels for procuring needed resources.
			❑ Alternative care plans have been developed for facility residents who need acute care services when hospital beds become unavailable.
			❑ Surge capacity plans include strategies to help increase hospital bed capacity in the community.
			- Signed agreements have been established with area hospitals for admission to the long-term care facility of non-influenza patients to facilitate utilization of acute care resources for more seriously ill patients.
			- Facility space has been identified that could be adapted for use as expanded inpatient beds and information provided to local and regional planning contacts.
			❑ A contingency plan has been developed for managing an increased need for post mortem care and disposition of deceased residents.
			❑ An area in the facility that could be used as a temporary morgue has been identified.
			❑ Local plans for expanding morgue capacity have been discussed with local and regional planning contacts.

CMS Centers for Medicare & Medicaid Services

The Who, What, When, Why & How of NPI: Information for Health Care Providers

- **Who?** All Individuals and Organizations who meet the definition of health care provider as described at 45 CFR 160.103 are eligible to obtain a **National Provider Identifier**, or NPI. If you are a HIPAA covered provider or **if you are a health care provider/supplier who bills Medicare** for your services, you need an NPI.

- **What?** The NPI is a 10-digit number that will be used to identify you to your health care partners, including all payers, in all HIPAA standard transactions. The NPI will replace the identifiers you currently use in HIPAA standard transactions that you conduct with Medicare and with other health plans. **You will need an NPI prior to enrolling with Medicare.** There are two types of health care providers in terms of NPIs:
  - Type 1 - Health care providers who are individuals, including physicians, dentists, and all sole proprietors. An individual is eligible for only one NPI.
  - Type 2 – Health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.
    - Organizations must determine if they have "**subparts**" that need to be uniquely identified in HIPAA standard transactions with their own NPIs. A subpart is a component of an organization that furnishes health care and is not itself a separate legal entity.
  - If you are an individual who is a health care provider and who is incorporated, you may need to obtain an NPI for yourself (Type 1) and an NPI for your corporation or LLC (Type 2).

- **When?** The NPI compliance date is **May 23, 2007**. However, CMS recommends that you obtain your NPI at least six months prior to this date to provide you with ample time to test your NPI and share it with all of your health care partners, including payers, clearinghouses, vendors, and other providers.

- **Why?** The NPI is an Administrative Simplification mandate of HIPAA.

- **How?** There are three ways that you can obtain your NPI. You can:
  - Complete the **on-line application** at the NPPES web site (https://NPPES.cms.hhs.gov/NPPES/Welcome.do);
  - Download the **paper application** form at www.cms.hhs.gov/NationalProvIdentStand/ and mail it to the address on the form; or,
  - After asking you for your permission, authorize an employer or other trusted organization to obtain an NPI for you through bulk enumeration, or **Electronic File Interchange** (EFI).

  Regardless of how you obtain your NPI, it is important that you **retain the notification document that NPPES sends to you** that contains your NPI. You may need to share this notification with other health care partners.

- **More:** Go to http://www.cms.hhs.gov/NationalProvIdentStand/ to find additional NPI information.

May 2006

MDS Coordinators, Take Note!

RAI User's Manual

January 2006 Update:
Http://www.cms.hhs.gov/NursingHomeQualityInits/downloads/MDS20Update200601.pdf

March 2006 Update:
http://www.cms.hhs.gov/NursingHomeQualityInits/downloads/MDS20Update200603.pdf

June 2006 Update:
http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS20Update200606.pdf

MDS Dave2 Fact Sheet:
http://www.cms.hhs.gov/NursingHomeQualityInits/downloads/MDS20DAVE2FactSheet.pdf

CDC Campaign to prevent antimicrobial resistance:
http://www.cdc.gov/drugresistance/healthcare/ltc/12steps_ltc.htm

Universal Precautions Rule Change
The Universal Precautions Rule amendments, LSA Document #05-259, became effective April 28, 2006. These amendments provide clarification to the existing requirements as well as update requirements based on best practices. Less stringent requirements would increase the likelihood that an individual exposed to blood or body fluids would acquire a dangerous communicable disease. The amendments are as follows:

- 410 IAC 1-4-1.1 amends the definition of bloodborne pathogens.
- 410 IAC 1-4-4.3 adds a definition of HCV.
- 410 IAC 1-4-8 updates the sterilization requirements for equipment and environmental surfaces.
- 410 IAC 1 may be accessed at: http://www.in.gov/legislative/iac/iac_title?iact=410&iaca=1 (page down to Rule 4)

Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment:
http://www.fda.gov/cdrh/beds/guidance/1537.pdf

ISDH/Residential Care Facility Roundtable

A roundtable discussion was held on Thursday, January 19, 2006, with the following representatives, Susan Albers, IALFA, Sue Hornstein, and Debbie Beers, ISDH.

Questions:

1. Please clarify the definition of "feeding" a resident.

Answer: **Providing food and/or drink in the residents mouth via hand and/or utensil.**

2. Has there been a change in QMA certification letters? Lately, some members have reported that there are no CNA certification numbers listed in addition to QMA numbers on their annual certificates.

Answer: **No change in the letters. A Q.M.A. must be an C.N.A.**

3. Is a CLIA waiver required in Residential Care Facilities when capillary blood glucose tests are completed?

Answer: **Yes, a CLIA waiver is required for any testing of body fluids. Please contact Wanda Proffitt, CLIA Program Director, Indiana State Department of Health, at 317/233-7502, if a CLIA application packet is needed.**

4. What documentation is required relative to advance directives?

Answer: **410 IAC 16.2-1.1-6 gives the definition for advance directives.**
410 IAC 16.2-5-1.2 (i) requires facilities to distribute upon admission the advance directives/your right to decide information.
410 IAC 16.2-5-8.1 (i)(8) requires the emergency information file contain a copy of the advance directives, if available.

410 IAC 16.2 may be accessed at:
http://www.in.gov/legislative/iac/T04100/A00162.PDF

Advance Directives/Your Right to Decide information may be accessed at:
http://www.in.gov/isdh/regsvcs/acc/advance/advanceddirectives.pdf

5. What is the readmission criteria when a resident returns from a hospital (in other words does he/she have to go through readmission)?

Answer: **410 IAC 16.2-5-2 (a), requires an evaluation must be completed prior to admission, semi-annually and upon a known substantial change. Following a hospitalization there may be a substantial change, if so an evaluation must be completed.**

6. Can portable liquid oxygen containers be filled in a resident's room?

Answer: **ISDH has no regulatory authority regarding fire safety in residential care facilities. Please contact the Indiana State Fire Marshall's office.**

7. What are the requirements for a qualified dietary manager (i.e. "experience in management")?

Answer: **The individual must have training and supervisory experience managing employees, as well as experience in the service process and the kitchen itself. This must be documented within the resume, as well as in reference checks.**

8. What is the definition of medication assistance?

Answer: Residents can be assisted with the following:

Opening a bottle
Administering eye drops (steadying only, not touching the bottle or applying pressure)
Applying topical creams and ointments (steadying only)
Providing reminders for insulin (note: facility can publish list of steps so that assistance can be provided in reading the list for the process while the resident self-administers the insulin)
Taking medications (if boxes are locked for the resident's protection, the keys must be located in the resident's room, keys can be retrieved and given to resident by staff, but residents must be able to unlock medication box)
Oxygen (assistance can be provided in filling the tanks and changing tubing on the tanks, but not with actual oxygen flow – resident or family member must be able to flip a switch for administration and change the flow of oxygen)
Catheters, no foley care of any type – one can assist in steadying or provide limited assistance in emptying of catheter bag
Providing and applying band aids (but no dressing changes)

9. Is there an expiration date for home health aide certification?

Answer: **There is none presently, but there will be soon.**

In an unlicensed facility, if a resident/resident/s family individually wants to contract with a private caregiver, who may or may not be a nurse or CNA, to perform some "typical licensed facility level activity" i.e. to check accuchecks for blood sugars perhaps de to resident trembling or poor eyesight, and the family has trained them. Is this allowed to be done in unlicensed assisted living? (The resident and family don't understand why this can't happen as this is "their home." What would prevent them from doing this? Also, would they have to have a written agreement to cover this? What if they (the caregiver) is not licensed or bonded?

Based on the above, the question is raised as to whether the resident or family of same has a right in an unlicensed model to contract privately with someone like the above. Many families want to go this route for cost saving purposes much like you may do in your own home if you found someone or knew someone who had a comfort level with whatever was needed, i.e. regular foley catheter care, etc. Would they need some sort of written contract? They are not necessarily going to have private duty from a private duty section of home care as they may not exist in the geographic are in question or be desired.

Answer: **There is no regulatory oversight in non-licensed residential care facility assisted livings. There may be home health requirements.**

11. Members want to know what is the regulation for oxygen usage by a resident in their room? Are there requirements for storage by the facility if stored outside of the building, i.e. does it have to be stored away from the building and if yes, how far? Are there any regulations about filling a portable container off of it in the facility?

Answer: **410 IAC 16.2-5-1.5 (j) specifies the sanitation and safety requirements. Please contact the Fire Marshall's Office for more specific fire safety requirements.**

12. If a physician has ordered PRN medications and the resident is requesting same, and it is within the parameters of the physician's order, can the facility assist the resident? That is, does the staff need to clear it with the nurse first, or if they are assisting with self-administration, can they act on the request of the resident if it is within the parameters set by the physician?

Answer: **Staff would not be involved if the resident is self-administering medication. Medication administration must be done by a QMA or licensed nurse. PRN medications may be administered by a QMA only upon authorization by a licensed nurse.**

13. I have searched the state regulations and have not been able to find where it talks about having the physician sign the resident's POS sheet every 90 days. I find under the pharmacy section where the pharmacist signs every 60 days. We have a physician that is not going to sign for a resident until he is paid $10.00 each time he receives these for signature. I was going to see how the regulations read before I contacted the physician, but no I cannot find it in our regulations. Can you help me with this?

Answer: **Facility policy should direct how often physician orders are renewed. There is no state residential rule regarding renewal of physician orders every 90 days. Renewal of physician orders will be at least yearly, unless specified differently by the physician. Facility policy may require renewal of physician orders more often than yearly.**

14. Can foley catheters be inserted in Residential Care? The description in the rules is very nebulous. If you can do intermittent cathing for established routines, why can't you do the cath insertion for a foley?

Answer: Please provide clarification for this question.

15. Do licensed people (CNAs, LPNs, RNs) require feeding assistant training?

Answer: **No**

16. Who is supposed to perform "CPR" Training?

Answer: **A certified trainer, i.e., American Heart Association or Red Cross trainer.**

17. Do licensed nurses (LPNs, RNs) require CPR training?

Answer: **Yes**

(05/25/06)

Round Table Questions and Answers
May 2006

1. The reportable unusual occurrence guidance includes misappropriation of resident property. Additionally, facilities are required to have a policy addressing missing or stolen items. Recently, a facility was directed that they must report to the local police department anything (or any amount of money) stolen. When questioned as to amount, the response given by a representative of ISDH was that as little as 59 cents is still considered misappropriation and should be reported. When this was addressed with local police department, they were in adamant opposition, stating that they would not file a report unless the amount was in multiple hundreds of dollars. Please clarify the expectations of ISDH.

Answer: Misappropriation of resident property is defined as deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. The report must be submitted within 24 hours after the preliminary investigation has determined that resident property or funds of any amount or size have been misappropriated.

Theft of any amount should be reported to the local police if it is "confirmed" that theft has occurred, meaning that it is believed that the money was stolen from the resident. If the local police state that the amount is insufficient for police involvement, the same should be documented to exhibit the facility's good faith effort to intervene on behalf of the resident

2. The reportable unusual occurrence guidance requires the reporting of "allegations" of abuse yet the definition for physical abuse states that resident –to-resident abuse would only be reported if there is injury. Thus, if there is an allegation made by a resident in regard to another resident, but there is no evidence of injury, should the "allegation" still yet be reported as there is no verification of injury?

Answer: Yes, the new policy effective 4-1-06 indicates the resident to resident physical abuse with or without injury is to be reported.

This is reportable if circumstances indicate one resident intended harm to a particular resident regard less of the resident's cognitive status.

3. When substandard level of care is identified in a facility, the surveyors request a list of all physicians who provide care for any resident of the facility; however, per review of enforcement guidance, it would appear that the state must issue notices to: "The attending physician of each resident who was identified as having been subject to substandard quality of care".

Answer: Yes, only those physician of residents' affected by the substandard quality of care need to be notified. The facility must provide ISDH a list of those physicians**.**

4. Please address the use of scope and severity of A, B, or C (which would still yet be substantial compliance). Can you provide examples as to what types of deficient practices would be cited within these categories?

Answer: Each deficiency is case sensitive. It is difficult to provide any specific examples**.**

5. Please provide clarification as to any guidance utilized by ISDH to discern whether a scope of "isolated versus "pattern" deficiency is determined.

Answer: The State Operations Manual guidance is followed when determining scope and severity. See attached SOM document

5. Please provide clarification as to any guidance utilized by ISDH to discern whether a scope of "isolated versus "pattern" deficiency is determined.

Answer: The State Operations Manual guidance is followed when determining scope and severity. See attached SOM document.

6. Facilities vary in practice as to mandating a physician's order for fall prevention devices which do not adhere to the resident (such as a personal alarm) and/or devices which are enabling to the resident (such as is the case when side rails are used as enablers versus restrictive devices). As these devices are not a medication or "treatment", per se, does the Department have a stance on whether a physician's order must be in place?

Answer: An enabler and/or personal alarms do not require a physician's order unless the facility's policy indicates a physician's order is required. If the side rail is a restrictive device, a physician's order is required.

7. Along the same line, a facility was cited for not documenting the type, size and number of side rails in the physician's order as well as addressing these three specific aspects on the care plan. In regard to side rail use, if the assessment states use of side rails is enabling, not restrictive, must there be an order? If so, how specific?

   If the use of side rails is restrictive, (keeping in mind that the State rule simply states, "restraint or seclusion shall be employed only by order of a physician, and the type of restraint or seclusion shall be specified in the order") is it anticipated that the order would include the type, size and number of rails?

Answer: A physician's order for a restrictive device must include the type of restrictive device to be used.

8. A facility was recently cited under F 157 for failure to notify the physician of abnormal laboratory values for a resident. The facility had notified the Nurse Practitioner who had a collaborative agreement with the attending Physician on file at the facility. Upon being questioned in regard to nurse practitioner involvement, the physician provided a letter to the survey team stating that he had "reviewed the summary of events and the nurse was correct in notifying the nurse practitioner first as this is the standard operating procedure" per the collaborative agreement. The facility responded to this citation, stating that the licensed nursing staff would receive in-service training relative to facility policy for physician and nurse practitioner notification of resident condition change as well as the collaborative agreement between the physician and the nurse practitioner, including the nurse practitioner's scope of practice."

   Correspondence was received from ISDH (requesting an addendum) regarding the deficiency (F157), stating, "Please refer to F390 regarding physician delegation of tasks in SNFs. Since your facility is SNF/NF dually certified, the physician may not delegate tasks in which the regulation is specific to the physician."

   Please clarify if the stance of the department is to prohibit the nurse practitioner to be contacted in lieu of the physician (keeping in mind that he/she would then be responsible to confer with the physician if deemed necessary, as per collaborative agreement). Such clarification is needed in that contacting the Nurse Practitioner initially is the common industry practice, and preference of physicians.

Answer: Duties to be carried out by the nurse practitioner should be delegated by the physician and written con firmation kept on file with the facility. If physician notification is delegated as a duty assigned to the nurse practitioner and the same is on file with the facility, there should be no concern with said notification via the nurse practitioner. A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies. For example, a physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.

ISDH/Residential Care Facility Roundtable
Tuesday, June 20, 2006

1. Which of the following are examples of a "self-limiting condition" with "standard disease-related clinical interventions?"

   Stage two pressure ulcer requiring daily cleansing with normal saline, application of a topical prescription ointment and covering with a dry, sterile dressing.
   Pneumonia requiring IV antibiotics once daily through a heparin lock.
   Stoma care of a temporary colostomy, emptying and changing the bag.

   Answer: 410 IAC 16.2-1.1-68 defines self-limiting. Self-limiting is specific to the individual resident.

2. As an AL community, we value the independence and autonomy of our residents, while providing for the safety and well-being of those residents.

   To do this, assess the resident's ability to act and make decisions as a prudent person would do in a like situation. To respect residents' rights, our communities do not secure its doors during the day and although we do monitor the movements of the residents, we do not require alert and oriented residents to alert us to his/her every movement.

   We feel, and have always felt, that this particular practice is within regulatory compliance for AL communities.

   Long term care regulations, on the other hand, require those kinds of facilities to provide a more structured, secured setting even for alert and oriented residents.

   How do we marry the collaborative relationship between the state and the communities to assure the regulations for AL, and not for LTC, are followed during survey?

   Answer: Comprehensive and Residential Care Facilities Rules require meeting the needs of the residents. If for example, a resident is at risk for wandering outside the facility, without regard to their safety needs, intervention(s) to assure the safety and welfare of the resident is necessary. Resident assessment or evaluation will direct the necessary intervention(s).

3. A community is being cited for the CNA and QMA working outside of their scope of practice because they "cared for fallen residents" on night shift on three occasions. The surveyor contended that they were assessing. Why have first aid and CPR certification? In first aid, they are taught to observe for visible injuries, and if present, call EMS. This is also in the community's corporate policies. The community checked with competitors, who also do the same thing. The surveyor felt that the staff should leave the person laying on the floor, even if the resident stated they were not hurt and wanted assistance to get up, until a "licensed nurse" was called in to assess the resident. Guidelines, please.

   Answer: If a resident is unable to get up on their own after a fall, a physical assessment for injury would be appropriate. C.N.A./Q.M.A's are not allowed to assess residents.

   (June 29, 2006)

DEPARTMENT OF HEALTH & HUMAN SERVICES
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-08

DATE: **March 10, 2006**

TO: State Survey Agency Directors
State Fire Authorities

FROM: Director
Survey and Certification Group

SUBJECT: **Nursing Homes** – Upcoming Compliance Date for the Installation of Emergency Lighting and the Replacement of Existing Roller Latches in Corridor Doors – March 13, 2006

Letter Summary

- On March 13, 2006 several fire safety requirements related to the adoption of the 2000 edition of the Life Safety Code take full effect.
- Procedures are outlined when deficiencies are found in replacement of roller latches and replacement of emergency lighting batteries.

The purpose of this memorandum is to notify States and Regional Offices (ROs) of the upcoming dates for nursing homes to comply with requirements concerning emergency light and the replacement of roller latches originally published January 10, 2003, in the **Federal Register** (Vol. 68, No. 7, page 1374) as a final rule entitled "Medicare and Medicaid Programs; Fire Safety Requirements for Certain Health Care Facilities." This regulation adopted the National Fire Protection Association (NFPA) 101 - 2000 edition of the Life Safety Code (LSC), and related changes to the fire safety regulations. Initial notice of adoption of the 2000 LSC and related changes were announced in S&C-03-21 dated May 8, 2003.

The above-mentioned regulation, which was effective March 11, 2003, gave facilities until March 13, 2006 to comply with two changes to the requirements. Those requirements included 1) replacing batteries used in emergency lighting, where required, to provide illumination for a minimum of 90 minutes; and 2) replacing roller latches commonly found in corridor doors with a positive latching device.

With the approaching compliance date of March 13, 2006 several States have asked about procedures that should be followed when surveying nursing homes that are not in compliance with either of these requirements when surveyed after March 13, 2006.

Beginning with fire safety surveys completed after March 13, 2006, deficiencies concerning the installation of 90-minute duration batteries used in emergency lighting shall be cited at Tag K-46, which deals with emergency lighting requirements. Deficiencies in the replacement of roller latches with a positive latching device shall be cited at Tag K-18, which includes requirements for corridor doors and latching requirements.

Deficiencies cited at either of these tags shall have a Scope/Severity level of D, E, or F depending on how widespread the deficiency is. **A waiver of either of these requirements, including temporary waivers, cannot be granted due to the negative impact on the health and safety of the residents of the facility and the regulatory requirements.**

If you have questions concerning this memorandum, please contact James Merrill at (410) 786-6998 or via email at James.Merrill@cms.hhs.gov.

Effective Date: All nursing home facilities must comply with the requirements of this rule by March 13, 2006.

Training: This information should be shared with all appropriate survey and certification staff, surveyors, their managers and state fire authorities and their staff.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
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Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-09

DATE: **March 10, 2006**

TO: State Survey Agency Directors

FROM: Director Survey and Certification Group

SUBJECT: **Nursing Homes -** Issuance of Revised Activities Guidance (Tags F248 and F249) as Part of Appendix PP, State Operations Manual, and Training Materials

Letter Summary

- Revised guidance for long-term care surveyors regarding Activities (Tags F248 and F249) will be effective June 1, 2006.
- An advance copy of this guidance and training materials are attached.
- This training packet is to be utilized in assuring that all surveyors who survey nursing homes are trained in the revised guidance by the implementation date.

Revised surveyor guidance for surveying Activities requirements in long-term care facilities will become effective on June 1, 2006. At that time, a final copy of this new guidance will be available at http://www.cms.hhs.gov/Transmittals/ and ultimately incorporated into Appendix PP of the State Operations Manual.

Here, we are providing an advance copy of the revised Activities guidance, which addresses the interpretive guidelines, the investigative protocol, and determination of compliance. The interpretive guidelines clarify areas such as assessment, care planning, interventions, and activity approaches for residents with behavioral symptoms. The investigative protocol explains objectives and procedures surveyors will need for their investigation. Deficiency categorization provides severity guidance for the determination of the correct level of severity of outcome to residents from deficiencies found at Tags F248 and/or Tag F249.

Also attached to this memo are training materials for the revised Tags F248 and F249. This training packet is to be utilized in assuring that all surveyors who survey nursing homes are trained in the revised guidance by the implementation date. These materials were presented and discussed in a teleconference with Regional Offices (ROs) on February 1, 2006. We encourage training to be conducted in person with group discussion to optimize learning. However, if this is not feasible to meet the needs of your surveyors, it is acceptable to use other methods. This guide may also be used to communicate with provider groups and other stakeholders.

RO training coordinators will document the completion of training on this newguidance for all RO and State nursing home surveyors within their region.

Enclosed with this memorandum are the following files:

- Guidance Training Instructor Guide – (pdf file);
- PowerPoint presentation file – (PowerPoint file); and

Advance copy of surveyor guidPage 2 – State Survey Agency Directors

RO training coordinators will document the completion of training on this new guidance for all RO and State nursing home surveyors within their region.

Enclosed with this memorandum are the following files:

- Guidance Training Instructor Guide – (pdf file);
- PowerPoint presentation file – (PowerPoint file); and

Advance copy of surveyor guidance on Tags F248 & F249 Guidance – (Word file).

For questions on this memorandum, please contact Karen Schoeneman at 410-786-6855 or via email at karen.schoeneman@cms.hhs.gov).

Effective Date: June 1, 2006. The State Agency should disseminate this information within 30 days of the date of this memorandum.

Training: The materials should be distributed immediately to all State Agencies and training coordinators.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Enclosures: Advance copy of Tags F248 and F249
PowerPoint Presentation
Training Instructor Guide

Enclosures can be viewed at the following link under Downloads:
http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS059715

DEPARTMENT OF HEALTH & HUMAN SERVICES
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Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-10

DATE: **March 10, 2006**

TO: State Survey Agency Directors

FROM: Director Survey and Certification Group

SUBJECT: **Nursing Homes -** Issuance of the New Psychosocial Outcome Severity Guide as Part of Appendix P, State Operations Manual, and Training Materials

Letter Summary

- New guidance for long-term care surveyors regarding the Psychosocial Outcome Severity Guide becomes effective June 1, 2006.
- An advance copy of this guidance and training materials are attached.

This training packet is to be utilized in assuring that all surveyors who survey nursing homes are trained in the

New surveyor guidance for using the Psychosocial Outcome Severity Guide (the Guide) for surveying long-term care facilities will become effective on June 1, 2006. At that time, a final copy of this new guidance will be available at http://www.cms.hhs.gov/Transmittals/ and ultimately incorporated into Appendix P of the State Operations Manual.

Here we are providing an advance copy of the Guide, which contains instructions, clarification of terms, and a severity guide. The Guide clarifies when to apply the "reasonable person concept." The clarification of terms provides specific definitions surveyors will need to apply the guidance. The severity guide provides criteria for the determination of the correct levels of negative psychosocial outcomes that developed, continued, or worsened because of the facility's noncompliance.

Also attached to this memo are training materials for the Psychosocial Outcome Severity Guide. This training packet is to be utilized in assuring that all surveyors who survey nursing homes are trained in this new guidance by the implementation date. These materials were presented and discussed in a teleconference with the Regional Offices (ROs) on January 18, 2006. We encourage training to be conducted in person with group discussion to optimize learning. However, if this is not feasible to meet the needs of your surveyors, it is acceptable to use other methods. The training materials may also be used to communicate with provider groups and other stakeholders.

RO training coordinators will document the completion of training on this new guidance for all RO and State nursing home surveyors within their region.

Enclosed with this memorandum are the following files:

- Advance copy of Psychosocial Outcome Severity Guide – (Word file):
- Training Instructor Guide – (pdf file); and
- PowerPoint presentation file – (PowerPoint file)

For questions on this memorandum, please contact Jeane Nitsch at 410-786-1411 or via email at Jeane.Nitsch@cms.hhs.gov).

Effective Date: June 1, 2006. The State Agency should disseminate this information within 30 days of the date of this memorandum.

Training: The materials should be distributed immediately to all State Agencies and training coordinators.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Enclosures: Advance copy of Psychosocial Outcome Severity Guide
PowerPoint Presentation
Training Instructor Guide

Enclosures can be viewed at the following link under Downloads:
http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS059716

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Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-11

DATE: **March 10, 2006**

TO: State Survey Agency Directors

FROM: Director Survey and Certification Group

SUBJECT: **Nursing Homes -** Issuance of Revised Surveyor Guidance for Quality Assessment and Assurance (Tags F520 and F521) as Part of Appendix PP, State Operations Manual, and Training Materials

Letter Summary

- Revised guidance for long-term care surveyors regarding Quality Assurance and Assessment (QAA) c condenses Tags F520 and F521 into one tag, F520, and will be effective June 1, 2006.
- System changes in preparation for these revisions will be effective April 3, 2006.
- An advance copy of this guidance and training materials are attached.

This training packet is to be utilized in assuring that all surveyors who survey nursing homes are trained in the revised guidance by the implementation date.

Revised surveyor guidance for surveying QAA requirements in long-term care facilities will become effective on April 3, 2006. At that time, a final copy of this new guidance will be available at http://www.cms.hhs.gov/Transmittals/ and ultimately incorporated into Appendix PP of the State Operations Manual. (Note: System changes in preparation for these revisions will be effective April 3, 2006)

We are providing an advance copy of the revised guidance, which contains interpretive guidelines, an investigative protocol, and deficiency categorization. The interpretive guidelines clarify the QAA committee functions, i.e., committee composition and frequency of meetings, identification of quality deficiencies, development of action plans, and implementation of action plans and correction of identified quality deficiencies. The investigative protocol explains the objectives and procedures surveyors will need for their investigation. The deficiency categorization provides severity guidance for the determination of the correct level of severity of outcome to residents from deficiencies found at Tag F520.

Also attached to this memo are training materials for the revised Tag F520. This training packet is to be utilized in assuring that all surveyors who survey nursing homes are trained in this new guidance by the implementation date. These materials were presented and discussed in a teleconference with Regional Offices on February 15, 2006. We encourage training to be conducted in person with group discussion to optimize learning. However, if this is not feasible to meet the needs of your surveyors, it is acceptable to use other methods. The training materials may also be used to communicate with provider groups and other stakeholders.

RO training coordinators will document the completion of training on this new guidance for all RO and State nursing home surveyors within their region.

Enclosed with this memorandum are the following files:

- Guidance Training Instructor Guide – (pdf file);
- PowerPoint presentation file – (PowerPoint file); and

Advance copy of Tag F520 Guidance – (Word file).

For questions on this memorandum, please contact Linda O'Hara at 410-786-8347 or via email at linda.ohara@cms.hhs.gov).

Effective Date: April 3, 2006. The State Agency should disseminate this information within 30 days of the date of this memorandum.

Training: The materials should be distributed immediately to all State Agencies and training coordinators.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Enclosures: Advance copy of Tag F520
PowerPoint Presentation
Training Instructor Guide

Enclosures can be viewed at the following link under Downloads:
http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS059717

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Center for Medicaid and State Operations/Survey & Certification Group

Ref: S&C-06-12

DATE: **March 22, 2006**

TO: State Survey Agency Directors

FROM: Director Survey and Certification Group

SUBJECT: State Operations Manual (SOM) Chapter 5, Complaints

Letter Summary

This memorandum summarizes changes reflected in the revised and reformatted Chapter 5 of the SOM, published on March 17, 2006.

Chapter 5 now covers basic complaint procedures for all providers and suppliers and includes pages numbers.

Chapter 5 of the SOM describes complaint procedures covering all providers/suppliers in the Medicare program. This revised chapter was developed by extracting and combining various sections on the complaint process from the previous paper-based manual and includes updated policy released in Survey and Certification letters through January 1, 2006. We also incorporated page numbers into this chapter.

An electronic copy of the revised and reformatted Chapter 5 is attached to this letter. It is organized into six different sections as follows:

- Section 5000 – 5080: General Information applicable to all Medicare providers/suppliers.
- Section 5100 – 5170: Complaint procedures for deemed providers/suppliers.
- Section 5200 – 5240: Complaint procedures for all non-deemed provider/suppliers, excluding nursing homes.
- Section 5300 – 5390: Complaint procedures for nursing homes.
- Section 5400 – 5480: Complaint procedures for EMTALA violations.
- Section 5500 – 5590: Complaint Procedures for CLIA-certified laboratories.

Any questions regarding this material can be directed to Cindy Melanson at 410-786-0310, or via email at cindy.melanson@cms.hhs.gov.

/s/
Thomas E. Hamilton

Attachment

cc: Survey and Certification Regional Office Management (G-5)

Attachment can be viewed at the following link under Downloads:
http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS060362

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Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-13

DATE: May 1, 2006

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **Nursing Homes -** Issuance of Revised Appendix P, State Operations Manual (SOM), Survey Protocol for Long Term Care Facilities

Letter Summary

This memorandum presents an advance copy of revisions to Appendix P which include:
Addition of the "Psychosocial Outcome Severity Guide;"
Addition of "Determining Citations of Past Noncompliance at the Time of the Current Survey" guidance;
Revisions to Tasks 2, 5F, and to II.B.3, The Traditional Post Survey Revisit (Follow-Up) to accompany the issuance of new guidance at F502 Quality Assessment and Assurance; and
Technical corrections.

The attached version of Appendix P will become effective June 1, 2006.

The purpose of this memorandum is to advise you of revisions we are making to Appendix P of the SOM, Survey Protocol for Long Term Care Facilities. The revisions include adding the Psychosocial Outcome Severity Guide to Part IV Deficiency Determinations, adding Determining Citations of Past Noncompliance at the Time of the Current Survey guide to Task 5, Information Gathering and to Task 6, Information Analysis for Deficiency Determination, and the revision of Tasks 2, 5F, and II.B.3. Also included in the revisions are corrections. All revisions to Appendix P will appear in red italics. The effective date for these revisions is June 1, 2006.

Revisions to Tasks 2, 5F, and to II.B.3, The Traditional Post Survey Revisit (Follow-Up) are being made to accommodate the issuance of the new Investigative Protocol in Tag F520 - Quality Assessment and Assurance. Task 5F remains a task of the survey process; however surveyors are referred in this task to use the Tag F520 Investigative Protocol. When training surveyors concerning the revised Guidance at Tag F520 please refer them to the changes at Tasks 2 and 5F as well.

New surveyor guidance is being issued for evaluation of the severity of any deficiency that has a psychosocial outcome to residents. This new Psychosocial Outcome Severity Guide is an addition to the current severity grid contained in Part IV Deficiency Categorization and is to be used in conjunction with the grid to address psychosocial outcomes of deficient practices.

Also added to Appendix P, Task 5, Information Gathering, is guidance for Determining Citations of Past Noncompliance at the Time of the Current Survey. This guidance provides surveyors with direction in determining whether correction of past noncompliance occurred and continues. It also provides surveyors with examples of interventions facilities could use to address the noncompliance.

Enclosed with this memorandum is the following file:

An advance copy of revised Appendix P– (Word file):

For questions on this memorandum, please contact Linda O'Hara at 410-786-8347 or via email at Linda.Ohara@cms.hhs.gov).

Effective Date: June 1, 2006.

Training: The materials should be distributed immediately to all State Agencies and training coordinators.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Attachment

Attachment can be viewed at the following link under Downloads:
http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS062560

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CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-16

DATE: **May 11, 2006**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Nursing Homes and Medicare Part D

Letter Summary

This memorandum clarifies residents' rights regarding choice of a prescription drug plan and pharmacy provider, the nursing homes' responsibility to provide drugs to residents, and State Survey Agencies' responsibilities with respect to the new Medicare prescription drug benefit and nursing homes:

- Residents have the right to make informed decision/choices about their care as described in sections §1802, §1851 and §1860 of the Social Security Act and 42 C.F.R. Part 483;
- Residents are guaranteed the right to choose a Part D **plan**, but do not have unbridled freedom to choose a **pharmacy**; and
- We expect nursing homes to work with their current pharmacies to assure that they recognize the Part D plans chosen by that facility's Medicare beneficiaries, or, in the alternative, to add additional pharmacies to achieve that objective. Or, at its option, the facility could contract exclusively with another pharmacy that contracts more broadly with Part D plans.

The purpose of this memorandum is to:

1. Answer questions surrounding nursing home pharmacy services following the January 01, 2006, implementation of the new Medicare prescription drug benefit relative to the:
   - Residents' right to choose their drug plan and pharmacy,
   - Nursing homes' regulatory compliance responsibilities, and
   - Surveyors' responsibilities.

2. Provide surveyors with a list of nursing home regulations that appear pertinent to the implementation of the Medicare Drug Benefit (Part D). The list is not exhaustive (Attachment A).

3. Provide surveyors with reference resources relative to Medicare Part D and nursing homes regulatory requirements (Attachments B&C).

4. Reinforce our commitment to provide high quality care and services to all beneficiaries.

Resident Rights

The freedom of choice provisions at sections §1802 and §1902(a)(23) of the Social Security Act provide that any individual entitled to insurance benefits under Medicare or Medicaid may obtain health services from any institution, agency, or person qualified to participate under this title. In addition, residents are guaranteed the right to choose their Medicare Prescription Drug Benefit Plan at section §1860D of the Social Security Act.

These provisions do not, however, give unbridled freedom of choice for nursing home residents to choose a pharmacy, with the exception of those states with a "right-to-choose" state law. Sections 1819(b)(4)(A)(iii) and 1919(b)(4)(A)(iii) of the Social Security Act require a skilled nursing facility and a nursing facility, respectively, to provide "pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident)." We believe these statutory provisions place the responsibility for accurately administering drugs on the nursing home and with that responsibility the right to define certain standards for labeling, packaging, storage, processing, and administration of drugs. These standards are essential in assuring that the resident is protected from medication errors.

Nursing home residents, like all other Medicare beneficiaries, have a right to choose their Part D plans. The statute, at section 1860D-1, and implementing regulations at 42 C.F.R. 423.32, ensure that right and do not lessen that right simply by virtue of the beneficiary's admission to a nursing facility. There may be cases where a nursing home acts in a way that frustrates a beneficiary's ability to receive cost effective coverage under Part D for needed prescription drugs under his or her preferred plan. For example, where the facility exclusively engages a pharmacy that does not have an arrangement with the Part D plan selected by the beneficiary, the beneficiary may be unable to obtain coverage of needed drugs through his or her Part D plan, and may incur higher Part D premiums and/or cost sharing if he or she must switch to an alternative plan in order to receive Part D coverage of his or her drugs. Or, a facility may overreach its authority and try to steer a resident to one or more Part D plans preferred by the facility or its pharmacy. Residents in such cases might feel compelled to choose another Part D plan that may not best satisfy their needs in order to conform to the wishes of the facility and its pharmacy. Such facility behavior would violate its obligations under the facility requirements of participation at 42 C.F.R. 483.12(d) which prohibit a facility from requiring residents to waive their Medicare rights. Additionally, failure by a facility to permit residents to receive coverage of needed drugs that would be available from the Part D plan of their choosing could constitute a violation of the facility's pharmacy obligations under 42 C.F.R. 483.60 which obligates facilities to acquire all drugs that meet the needs of each resident. Accordingly, we expect nursing homes to not frustrate a beneficiary's choice in Part D plans, and to work with pharmacies to make sure that a resident's choices are honored so that there is no disruption in the provision of necessary drugs. Specifically, we expect nursing homes to work with their current pharmacies to assure that they recognize the Part D plans chosen by that facility's Medicare beneficiaries, or, in the alternative, to add additional pharmacies to achieve that objective. Or, at its option, the facility could contract exclusively with another pharmacy that contracts more broadly with Part D plans.

Facility Regulatory Compliance Responsibility

Nursing homes must have a safe and accurate system for the delivery of medications to their residents. While nursing homes are free to use multiple pharmacies, the first priority of 42 C.F.R 483.60 is to assure that nursing homes provide needed medications for each resident, without errors." Therefore, safety should be considered when making determinations relative to the residents' medications.

Since nursing homes are responsible for the safety and efficacy of the medication delivery system to their residents, they hold the responsibility for selecting a pharmacy or pharmacies that are willing and able to accommodate the Medicare Prescription Drug Benefit Plans chosen by all residents of their nursing home.

Under no circumstances should a nursing home require, request, coach, or steer any resident to select or change a plan for any reason. Furthermore, a nursing home should not knowingly and/or willingly allow the pharmacy servicing the nursing home to require, request, coach, or steer any resident to select or change a plan [42 C.F.R. §483.12(d)]. Nursing homes may, and are encouraged to, provide information and education to residents on all available Part D plans.

Nursing homes should provide residents with an explanation, on admission or immediately if the resident is already in the nursing home at the time of the plan implementation, of their right to choose their prescription drug benefit plan [42 C.F.R. §483.12(d)].

Surveyor Responsibility

State Survey Agencies will continue to monitor nursing homes for compliance with regulations as outlined in the regulations at 42 C.F.R. Part 483 and accompanying surveyor guidance. For example, surveyors should cite §483.60 (F426) if nursing homes are not providing pharmaceutical services to meet the need of each resident.

To the extent a survey or complaint investigation finds the resident's right to choose a Part D plan is denied as a result of pharmacy limitations, or for any other reason, surveyors should:

- Educate nursing home administrators as to the distinction between a resident's choices of plans, the nursing home's choice of pharmacies, and the nursing home's responsibility to protect the resident's right to Part D plan choices.
- Cite §483.12(d) (F208) if residents are denied the right to select their prescription drug plan, and encourage the nursing home to develop and implement an effective and timely plan of correction.

CMS' Survey and Certification Program

If a complaint involves both a CMS regulatory requirement for nursing homes (such as the residents' rights issue discussed above) and a Part D requirement, the surveyor should act on the survey issue and also notify the appropriate Part D authority.

The appropriate Part D authority is the Part D case manager working in your region.

For further information please contact Debra Swinton-Spears at (410) 786 -7506 or e-mail at debra.swinton-spears@cms.hhs.gov.

Effective Date: Immediately. Please ensure that all appropriate staff are informed within 30 days of the date of this memorandum, and disseminate the information to affected providers.

Training: The information contained in this announcement should be shared with all survey and certification staff, their managers, and the State/RO training coordinators.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Attachments

Attachments can be viewed at the following link:
http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS063301

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-17

DATE: **May 11, 2006**

TO: State Survey Agency Directors

FROM: Director Survey and Certification Group

SUBJECT: For Your Information - Sunset of the Policies for Provider Nominations for an Intermediary and the Provider Requests for a Change of Intermediary

Letter Summary

- On February 17, 2006 the Centers for Medicare & Medicaid Services (CMS) made a revision to the Medicare Claims Processing Manual, Pub 100-04 via Transmittal 861, "Sunset of the Policies for Provider Nominations for an Intermediary and the Provider Requests for a Change of Intermediary."
- Effective with the release of the Transmittal, new freestanding providers are no longer able to express a preference for a particular intermediary; they must be assigned to the designated local intermediary. Existing providers will no longer be able to request a change of intermediary; they must remain with the intermediary to which they have been assigned.
- The new policy also applies to changes of ownership (CHOW).

A copy of the Transmittal is attached.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Section 911(d)(2)(B) allows CMS to take appropriate steps to transition from agreements under Section 1816 of the Act to contracts with Medicare Administrative Contractors The provider nomination provisions expired on September 30, 2005.

The purpose of this memorandum is to notify the State Survey Agencies (SAs) and CMS Regional Offices (ROs) and that the provider nomination provisions and the change of intermediary policy have sunset. Effective immediately, new freestanding providers are no longer permitted to express a preference for a particular fiscal intermediary (FI). New providers must be assigned to the designated local FI. In addition, providers may no longer request a change of FI and must continue with the FI to which they have been assigned.

The new policy also applies to situations where there is a change of ownership (CHOW). If the new owner does not accept assignment of the existing provider agreement, the new owner will be considered as a new enrollee. It must complete the application process, have the SA perform a survey, and receive approval from the RO. The provider is then given a new provider number and is assigned to the local designated FI. If the new owner, following a CHOW, accepts assignment of the existing provider agreement, it will continue with the same FI as the previous owner.

This recent change to Pub. 100-04, "Medicare Claims Processing Manual," was effectuated on March 17, 2006 via Transmittal 861, a copy of which is attached to this memo.

For questions on this memo, please contact Kathryn Linstromberg at (410) 786-8279 or e-mail at kathryn.linstromberg@cms.hhs.gov.

Effective Date: Immediately. The state agencies should disseminate this information within 30 days of the date of this memorandum.

Training: The information contained in this announcement should be shared with all survey and certification staff, surveyors, their managers, and with managers who have responsibility for processing initial Medicare certifications and CHOWs.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Managers (G-5)
Accrediting Organizations

Attachment

Attachments can be viewed at the following link under downloads:
http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS063303

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-18

DATE: **May 26, 2006**

TO: State Survey Agency Directors
State Fire Authorities

FROM: Director
Survey and Certification Group

SUBJECT: **Life Safety Code -** Clarification of the Amount of Air Movement Allowed Between Corridors and Resident Rooms and Plenum Waiver Requirements

Letter Summary

- Clarifies what an acceptable amount of incidental air movement is in assessing whether a corridor is a plenum.
- Addresses waiver criteria for facilities where a corridor is being used as a plenum in facility ventilation systems.

The purpose of this memorandum is to clarify and reiterate the Centers for Medicare & Medicaid Services' (CMS) policy and give additional survey guidance regarding the use of corridors as plenums in the ventilation systems of health care facilities. A plenum is a compartment or chamber to which one or more air ducts are connected and that forms part of a facility's air distribution system.

The National Fire Protection Association (NFPA) 90A, "Installation of Air Conditioning and Ventilating Systems" document, 1999 Edition prohibits egress (exit) corridors in health care occupancies from being used as a portion of the supply, return or exhaust air system serving adjoining areas (2-3.11.1, 1999 ed.). This prohibits the corridor from being used as a plenum. An example of when a corridor is being used as a plenum is when air is pumped into the resident rooms without provision for exhausting/removing the air from the room and the air flows into the corridor. This could accelerate the spread of smoke and toxic gases during a fire in a room. Another situation could exist where air flows from the corridor into the resident rooms. Many older health care facilities contain ventilation systems where the corridor is being used as a plenum as an alternative to upgrading the facility's air distribution system.

Some incidental movement of air between residents' rooms off an egress corridor and the corridor is permitted (2-3.11.1), and does not cause the corridor to be considered a plenum. This incidental air movement can be caused by such things as bathroom fan exhaust systems when the bathroom is connected to the resident's room.

Recently at meeting with the chairman and a few members of the NFPA 90A Technical Committee, it was determined that air exhausted from the bathroom and drawn from the room in general could be made up in whole or in part from infiltration around and under the corridor room door. It was explained by the representatives from the Technical Committee that this quantity of air movement would not cause the corridor to be considered a plenum.

In cases where it is determined that the corridor is being used as a plenum and the deficiency is cited at tag K-067, a waiver may be granted. The following criteria should be used to document "no adverse effect on health and safety" when considering the waiver request.

- **Fully Sprinklered Building**: If the building is protected throughout by a complete supervised automatic sprinkler system in accordance with section 9-7, NFPA 101 2000 edition, a waiver may be recommended.

- **Partially Sprinklered or Unsprinklered Building**: If the zone with the corridor plenum is protected by a complete corridor smoke detection system, and there is provision for automatic fan shut down upon detection of smoke and activation of the building fire alarm system, a waiver may be recommended. If the existing fire alarm control panel(s) does not have sufficient capacity to handle the additional corridor detectors, new control panels may be required.

We hope this information is useful in clarifying this issue. If you have further questions, regarding this matter, please contact James Merrill at James.Merrill@cms.hhs.gov.

Effective Date: The information contained in this memorandum is current policy and is in effect for all nursing home facilities. The State agency should disseminate this information within 30 days of the date of this memorandum.

Training: This clarification should be shared with all survey and certification staff, fire authorities, surveyors, their managers, and the State/RO training coordinator.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

DEPARTMENT OF HEALTH & HUMAN SERVICES
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-19

DATE: **May 26, 2006**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **Nursing Homes** - Issuance of New Tag F356, Appendix PP, State Operations Manual (SOM), Survey Protocol for Long Term Care Facilities Regarding Posting of Staffing Information. This letter replaces our previous guidance to use Tag F492 for this issue.

Letter Summary

- New Tag F356 has been developed for use in citing noncompliance regarding posting of nurse staffing information in lieu of Tag F492.
- Tag F356 is effective immediately upon its availability after the ASPEN release in June.
- Tag F492 remains for other issues involving compliance with Federal, State, and local laws; however, previous direction (S&C-03-11) to cite deficiencies in posting at Tag F492 is rescinded.

The purpose of this memorandum is to advise you that we are implementing a new regulatory tag, F356, for citation of deficiencies regarding the posting of nurse staffing information as contained in regulation at 42 C.F.R. §483.30(e). The change will be issued in June as part of the general changes that are already planned to Appendix PP that will introduce Paid Feeding Assistant and Immunization regulatory language and to make other technical corrections. This letter only rescinds use of the particular deficiency tag, F492, described in S&C-03-11 to cite deficiencies in nurse staffing posting for compliance with Federal, State, and local laws. Tag F492 remains for other issues involving compliance with Federal, State, and local laws. **New Tag F356 will be added to Aspen for the June 2006 release.**

For questions on this memorandum, please contact Linda O'Hara at 410-786-8347 or via email at Linda.Ohara@cms.hhs.gov).

Effective Date: Immediately upon its availability after the ASPEN release in June 2006.

Training: This information should be distributed immediately to all State Agencies and training coordinators.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

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Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
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CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-20

DATE: **June 15, 2006**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **Nursing Homes** – Implementation of the New Psychosocial Outcome Severity Guide

Letter Summary

- CMS delayed the June 1, 2006 implementation of the Psychosocial Outcome Severity Guide.
- The Psychosocial Outcome Severity Guide is implemented and effective as of June 8, 2006.
- There were no changes to the Psychosocial Outcome Severity Guide from the advance copy version released on March 10, 2006 in memorandum S&C-06-10.

This is to announce the implementation of the Psychosocial Outcome Severity Guide (the Guide) for surveyors of long term care facilities. The Guide was sent out in an advance copy on March 10, 2006 in memorandum S&C-06-10 and was originally scheduled to be effective June 1, 2006. CMS delayed implementation so that CMS could respond to concerns from one of our stakeholders. The Guide is now effective as of June 8, 2006. No changes have been made to the Guide that was sent out as an advance copy in memorandum S&C-06-10. The final copy of the Guide will be available at http://www.cms.hhs.gov/Transmittals/ and incorporated into Appendix P of the State Operations Manual.

For questions on this memorandum, please contact Jeane Nitsch at 410-786-1411 or via email at Jeane.Nitsch@cms.hhs.gov.

Effective Date: June 8, 2006.

Training: This information should be distributed immediately to all State Agencies and training coordinators.

/s/

Thomas E. Hamilton
Director

cc: Survey and Certification Regional Office Management (G-5)